N432 Focus Sheet #2 Fall 2019

Ricci, Kyle, & Carman Ch 13, 14, 21 and ATI Ch 11, 12, 13, 14, 15,16 Focused Reading

1. Fill in the following table with associated s/s of each

	TRUE LABOR	**FALSE LABOR**
Uterine Contractions (Braxton Hicks)	• can begin irregularly but become more regular in frequency • stronger, longer, more frequent • felt in lower back, radiating to abdomen • walking can increase contraction intensity • continue despite comfort measure	• painless, irregular frequency, intermittent • decrease in frequency, duration, and intensity with walking or position changes • felt in lower back or abdomen above umbilicus • often stop with sleep or comfort measures such as oral hydration or voiding
Cervical Dilation & Effacement	• progressive change in dilation and effacement • moves to anterior position	• no significant change in dilation or effacement • often remains in posterior position
Bloody show	• present	• not present
Fetus: Engagement	• presenting part engaged into pelvis	• presenting part is not engaged in pelvis

2. Define lightening.
    a. fetal head descends into true pelvis about 14 days before labor; feeling that the fetus has dropped, easier breathing, but more pressure on the bladder, resulting in urinary frequency; more pronounced in clients who are primigravida

3. Describe the Bishop score and the indications for doing it.
    a. maternal readiness
        i. scores per category is 0-3
        ii. score should be greater than 8 for multiparous
        iii. score should be greater than 10 for nulliparous

1. position
2. consistency
3. effacement
4. dilation
5. baby's station

4. What are Leopold's maneuvers (make sure to understand all 4 maneuvers) and what 4 questions do each maneuver answer?
    a. 1. identify fetal part→ presentation
    b. 2. locate & palpate fetal back→ validates presenting part
    c. 3. what part is presenting over true pelvis→ descent into pelvis
    d. 4. outline fetal head to palpate cephalic prominence→
        i. number of fetuses
        ii. presenting part, lie, and attitude
        iii. location of fetal back to assess for heart tones
        iv. degree of descent

5. List the "pre procedures" done on admission to labor and delivery.
    a. leopold maneuvers
        i. abdominal palpation of the number of fetuses, fetal presenting part, lie, attitude, descent, and probable location where fetal heart tones can be best auscultated in woman's abdomen
    b. external electronic monitoring (tocotransducer)
        i. separate transducer applied to the maternal abdomen over the fundus that measures uterine activity
            1. displays contraction patterns
            2. easily applied by the nurse but must be repositioned with maternal movement
    b. external fetal monitoring (EFM)
        i. transducer applied to abdomen of patient to assess FHR patterns during labor and birth
    b. group b streptococcus
    c. urinalysis
    d. blood tests
        i. CBC level
        ii. ABO typing and Rh-factor if not done previously

6. State the 5 "P's" of the labor progress and what each P is composed of.
    a. passageway (birth canal)
    b. passenger (fetus & placenta)
    c. powers (contractions)
    d. position (maternal)
    e. psychological response

7. Define fetal lie and fetal attitude.
    a. fetal attitude is the relationship of fetal body parts to itself
    b. fetal lie refers to the long axis of the fetus to the long axis of the mother

8. What role do the fetal skull suture lines and fontanelles play in identifying fetal position?
a. During a pelvic examination palpation of sutures by the nurse reveals the position of the fetal head and the degree of rotation that has occured.

9. Define the various fetal presentations (RKC p 462-464 & ATI p 74).
    a. the part of the fetus that is entering the pelvic inlet first and leads through the birth canal during labor. it can be the back of the head, chin, shoulder, or breech

10. What do each of the 3 letters associated with fetal positioning stand for?
    a. 1st letter refers to side of maternal pelvis
        i. right (R) or left (L)
    b. 2nd letter refers to presenting part of fetus
        i. occiput (O), sacrus (S), mentum (M), scapula (Sc)
    b. 3rd letter refers to part of maternal pelvis
        i. anterior (A), posterior (P), transverse (T)

11. Fetal station is assessed in relation to what?
    a. fetal station is assessed in sm with station 0 being at the level of an imaginary line at the level of the ischial spines, minus stations superior to the ischial spines, and plus stations inferior to the ischial spines

12. Outline the rationale for and the pros and cons of external cephalic version.
    a. external cephalic version is an ultrasound guided hands-on procedure to externally manipulate the fetus into a cephalic lie done at 36-37 weeks in a hospital settings
        i. cons
            1. placental abruption
            2. umbilical cord compression
            3. emergent c-section

13. Describe methods of cervical ripening and the indications for their use?
    a. cervical ripening by various methods increases cervical readiness for labor through promotion of cervical softening, dilation, and effacement
        i. eliminates need for oxytocin to induce labor
        ii. balloon catheter used to dilate the cervix
        iii. membrane stripping and amniotomy
        iv. hygroscopic dilators may be inserted to absorb fluids
        v. chemical agents to soften and thin the cervix

14. Use this chart to summarize the Stages & phases of labor. Write it so that it makes sense to you.

Stage of Labor	***What is happening during this Stage/Pha***	***Expected effacement & dilation***	***Expected Frequency of Contractions***	***Expected duration of contractions***	***Anticipated Nursing assessments & interventions***

	se?	***of cervix***			
First Stage 1. Latent 2. Active 3. Transition	1.onset of labor, contractions are irregular, mild to moderate 2.contractions are more regular, moderate to strong 3.contractions are strong to very strong	1. p 1cm/hr; m1.5 cm/hr 2. p 1cm/hr; m1.5 cm/hr 3. p 1cm/hr; m1.5 cm/hr	1. 5 to 30 mins 2. 3 to 5 mins 3. 45-90 seconds	1. 30 to 45 seconds 2. 40-70 seconds 3. 45-90 seconds	1. teach client and their partner about what to expect during labor and implement relaxation measures 1. encourage upright postions, application of warm/cold packs, ambulation, or hydrotherapy (if not contraindicated) 2. encourage voiding every 2 hours 3. active phase - provide client/fetal monitoring, encourage frequent position changes, encourage relaxation and provide non pharmacological comfort measures, provide pharmacological pain relief as prescribed 4. transition phase - discourage pushing until cervix is fully dilated, if client

					expresses the need for BM this can be indicative of complete dilation
Second Stage	full dilation progresses to intense contractions every 1-2 mins	full dilation	p- 3o mins-2 hr m- 5-30 mins	Q 1-2 mins	1. assist in positioning the client for effective pushing 2. assist partner involvement with pushing efforts 3. promote rest between contractions 4. provide comfort measures 5. cleanse perineum as needed 6. provide support and feedback 7. prepare for care of neonate
Third Stage	delivery of neonate and placenta	full	5-30 mins	neonate is introduced into outside world occasional contractions are noted to encourage placenta expulsion	1.Instruct client to push once findings of placental separation are present 2. administer oxytocics as prescribed 3. administer analgesics 4. gently cleanse perineal area; apply perineal pad or ice pack 5. promote baby-friendly activities between the family and the newborn
Fourth Stage	delivery of placenta and maternal stabilization of vital signs	full	1-4 hr	encourage maternal neonate bonding, uterus contracting to finish process	1. assess maternal blood pressure and pulse every 15 min for the first 2 hr 2. assess fundus and lochia every 15 min for first hour 3. massage uterine fundus and/or

					administer oxytocics to maintain uterine tone and prevent hemorrhage 4. encourage voiding 5. assess episiotomy or laceration repair 6. promote parental-newborn bonding 7. encourage rest

15. How can we confirm rupture of membranes?
    a. pH test
    b. Nitrazine Test

What is our priority nursing intervention after confirmation of rupture of membranes?

- assist the physician
- document temperatures -Q2hr when ruptured
- document time of rupture, color, amount, any odor, consistency
- ensure or check that presenting part is engaged
- maternal comfort-changing pads
- monitor FHR: assessing for lates/variables

16. What information do we want to gather from the mother about rupture of membranes if we did not witness it?
    a. Be sure to ask whether the patient is contracting, bleeding vaginally, has had intercourse recently, or has a fever
    b. The physician should perform a speculum examination to evaluate if any cervical dilation and effacement are present

17. Describe when an induction might be warranted and the difference between induction and augmentation?
    a. augment- stimulation of contractions once labor has started
    b. induce- initiation of UC to stimulate labor before spontaneous onset

18. Describe what an amniotomy is, the indications for it to be done, and the considerations.
    a. artificial rupture of membranes (AROM) utilizing an amnihook
    b. risks: cord prolapse/infection

19. **Medications:** *What is each medication used for? What does it do? Nursing indications/interventions?*

Oxytocin	Acts on uterine myofibrils to contract/to initiate or reinforce labor. Administer as an IV infusion via pump, increasing dose based on protocol until adequate labor process is achieved. Assess

	baseline vitals and FHR and then frequently after initiating oxytocin infusion. Determine frequency, duration, and strength of contractions frequently. Monitor for possible adverse effects such as hyperstimulation of the uterus and imparied uterine blood flow leading to fetal hypoxia.
Misoprostol	Ripens cervix/to induce labor. Instruct client about purpose and possible adverse effects of medication. Ensure informed consent is signed per hospital policy. Assess vital signs and FHR patterns frequently. Monitor client's reaction to drug. Initiate oxytocin for labor induction at least 4 hours after last dose was administered. Monitor for possible adverse effects such as nausea and vomiting, diarrhea, uterine hyperstimulation, and category II FHR patterns.
Penicillin G	Treatment of choice for GBS infection because of its narrow spectrum. The drug is usually administered intravenously at least 4 hours before birth so that it can reach adequate levels in the serum and amniotic fluid to reduce the risk of newborn colonization. Close monitoring is required during the administration of intravenous antibiotics because severe reactions can occur rapidly.
Methylergonovine	Stimulates the uterus. Prevents and treats postpartum hemorrhage due to atony or subinvolution. May be repeated in 5 min, thereafter every 2-4 hr. Assess baseline bleeding, uterine tone, and vital signs every 15 min or according to protocol. Offer explanation to client and family about what is happening and the purpose of the medication. Monitor for possible adverse effects, such as hypertension, seizures, uterine cramping, nausea, vomiting, and palpitations.
Betamethasone	Promotes fetal lung maturity by stimulating surfactant production; prevents or reduces risk of respiratory distress syndrome and intraventricular hemorrhage in the preterm neonate less than 34 weeks gestation. Administer two doses intramuscularly 24 hr apart. Monitor for maternal infection or pulmonary edema. Educate parents about potential benefits of drug to preterm infant. Assess maternal lung sounds and monitor for signs of infection.
Terbutaline Sulfate	Betamimetic; prevent and slow contractions of the uterus. Used to stop or delay preterm labor; can delay birth for several hours or days. Given subcutaneously or IV. Total dose should not exceed 0.5 mg and shouldn't be used for more than two days at a time. Monitor maternal/fetal VS regularly, monitor maternal/fetal blood glucose. Do not give to women with heart conditions, hyperthyroidism or poorly controlled diabetes.
Methotrexate	Used to treat ectopic pregnancies; works by stopping the growth of the fertilized egg before rupture occurs. Given IM; in some cases up to three injections are necessary. Monitor pregnancy hormone levels, administer vitamins, antibiotics, and analgesics as prescribed

Indomethacin	Inhibits prostaglandins, which stimulate contractions; inhibits uterine activity to arrest preterm labor. Continuously assess vital signs, uterine activity, and FHR. Administer oral form with food to reduce GI irritation. Do not give to women with peptic ulcer disease. Schedule ultrasound to assess amniotic fluid volume and function of ductus arteriosus before initiating therapy; monitor for signs of maternal hemorrhage. Be alert for maternal adverse effects such as nausea and vomiting, heartburn, rash, prolonged bleeding time, and hypertension. Monitor for neonatal adverse effects, including constriction of ductus arteriosus, premature ductus closure, necrotizing enterocolitis, oligohydramnios, and pulmonary hypertension.
Magnesium Sulfate	Used to stop/delay preterm labor; inhibits uterine contractions. given IV; initial infusion of 4-6 grams over 15-30 minutes, followed by a maintenance dose of 2-3 g/hr. Monitor maternal/fetal VS regularly, monitor Mg levels, monitor I/Os. Do not give to women with myasthenia gravis.
Naloxone	Opioid antagonist. Administered to combat the effects of analgesics. Monitor maternal/fetal VS
Calcium Gluconate	given as calcium supplement during pregnancy. Given only if it is absolutely necessary to prevent calcium deficiencies. The exact side effects to pregnancy are unknown. Monitor maternal/fetal well being, monitor maternal/fetal VS, monitor calcium levels
Narcan	Opioid antagonist. Administered to combat the effects of analgesics. Monitor maternal/fetal VS

20. List procedures done during labor (“intra partum”).
    a. assess maternal VS
    b. assess FHR
    c. assess uterine labor contraction characteristics
    d. intrauterine pressure catheter
    e. vaginal examination
    f. mechanism of labor in vertex presentation

21. Define each of the 6 cardinal movements of labor (Mechanisms of labor).
    a. engagement: occurs when the presenting part passess the pelvic inlet at the level of the ischial spines
    b. descent: the progress of the presenting part through the pelvis
    c. flexion: when the fetal head meets resistance of the cervix, pelvic wall, or pelvis floor. the head flexes, bringing the chin close to the chest for a smaller diameter to pass the pelvis
    d. internal rotation: the fetal occiput ideally rotates to a lateral anterior position as it progresses from the ischial spines to the lower pelvis in a corkscrew motion to pass through the pelvis

e. extension: the fetal occiput passes under the symphysis pubis, and then the head is deflected anteriorly and is born by extension of the chin away from the fetal chest
f. external rotation (restitution): after the head is born, it rotates to the position it occupied as it entered the pelvic inlet in alignment with the fetal body and completes a quarter turn to face transverse as the anterior shoulder passes under the symphysis
g. birth by expulsion: after the birth of the head and shoulders, the trunk of the neonate is born by flexing it toward the symphysis pubis

22. Describe the benefits for a woman to change position while in labor. Include what suggestions the nurse can give the laboring woman about position changes?
    a. Benefits of changing position during labor include enhancing comfort, relieving fatigue, and promoting circulation. Position is dependent on maternal and provider preference and the condition of mother and fetus. Gravity can aid in the fetal descent in upright, sitting, kneeling, and squatting positions.

23. What are the 4 techniques used to assess ongoing data during labor and birth?
    a. Maternal vital signs (temperature, blood pressure, pulse, respiration, and pain), review prenatal record to identify risk factors that may contribute to a decrease in circulation during labor, assess uterine activity, monitor fetal heart rate

24. What is a vaginal exam (SVE-sterile vaginal exam)? How often should it be done according to WHO (World Health Organization)?
    a. Sterile digital exam completed by qualified RN, CNM, or MD. Sterility is maintained on gloved hand of choice and sterile water-soluble lubricant is used. Recommended to only be done when warranted by patient's presenting signs and symptoms or a provider order.

25. Why is important to assess frequency, duration and intensity of contractions?
    a. Assessing frequency, duration, and intensity of contractions is necessary to track the progression of delivery. Duration is timed from the first onset of a contraction to when it is over; measured in seconds. Frequency is timed from the start of one contraction to the start of the next; measured in seconds. Intensity is measured by how intensely they are felt by the mother; on a numeric scale.

26. What 2 ways can you assess uterine contractions?
    a. time the frequency and duration of contractions

27. To palpate uterine contraction intensity, a mild contraction feels like your __nose_____ , a moderate contraction feels like your __chin___, and strong contraction feels like your ___forehead_____.

28. List the sources of pain during labor.
    a. stage 1
        i. dilation
        ii. effacement
        iii. stretching
        iv. distention of lower segment of uterus
    b. stage 2
        i. pressure and distention of vagina, perineum “burning, splitting, tearing”
        ii. pressure and pulling of pelvic structures
        iii. lacerations of soft tissues
    b. stage 3
        i. uterine contractions
        ii. pressure and pulling of pelvic structures
    b. stage 4
        i. distention and stretching of vagina and perineum

29. List how pain assessment is done during labor.
    a. pain is not always measured by monitoring outward expressions
    b. persistent questioning and observation
    c. anxiety and fear
    d. assess beliefs and expectations related to pain, birth plans, and pain relief
    e. assess level, quality, duration, and frequency of contractions
    f. use appropriate pain scale 0-10

30. List 3 non pharmacologic pain intervention methods.
    a. sensory stimulation strategies
        i. imagery
        ii. music
        iii. breathing
    b. cutaneous stimulation strategies
        i. therapeutic touch, walking, rocking
    b. cognitive strategies
        i. childbirth education
        ii. biofeedback

31. Describe how epidural analgesia is administered, what are the implications, and what is the difference between this and a spinal epidural?
    a. short acting opioids that are administered as a motor block into the epidural or intrathecal space without anesthesia. produce regional analgesia, providing rapid pain relief while still allowing patient to sense contractions and maintain ability to bear down
    b. implications
        i. decreased gastric emptying (nausea/vomit)
        ii. loss of bowel and bladder sensation
        iii. bradycardia or tachycardia
        iv. hypotension
        v. respiratory depression

32. What added considerations are there for the nurse caring for a woman who has undergone general anesthesia?
    a. safety precautions (putting up bed rails)
    b. assess for nvd to prevent aspiration
    c. monitor VS, allergic reaction and continue FHR pattern monitoring
    d. NPO, ted hose stockings in use

COMPLETE Q32 & Q33 after you review R,K,C p 492-498 and ATI p86-89 for understanding of fetal monitoring and you complete the Online Fetal monitoring program

33. Where in the contraction do the increment, acme and decrement happen?
    a. increment - uterine muscles contract and the force increases in strength; acme - peak of contraction intensity; decrement - gradual decrease in strength until muscles are relaxed

34. Briefly describe what Category I, Category II and Category III fetal heart rate tracings look like.
    a. category I - baseline fetal heart rate of 110-160 bpm; moderate variability; accelerations and early decelerations may be absent or present; late decelerations are absent
    b. category II - contains all tracings not categorized by I or III
    c. category III - include either sinusoidal pattern, absent baseline fetal heart rate variability and any of the following: recurrent variable decelerations, recurrent late decelerations, or bradycardia

35. Why is support so vital for laboring women? What is a doula? What is a CNM?
    a. Research has shown women with solid support systems during labor have shorter labors, control their pain better and have less need for medical intervention.
    b. A doula is trained and well-experienced in childbirth; they help the mother develop a birth plan by providing education and support and can offer service during and after childbirth if requested
    c. CNM - certified nurse-midwife; provide health and wellness care to pregnant women include family planning, gynecological checkups and prenatal care

36. What is “crowning”?
    a. baby’s head begins to emerge from the birth canal during the second stage of labor

37. List a summary of assessments during second , third and fourth stages of labor.
    a. second stage - assess blood pressure, pulse, and respiration rate every 5-30 min; monitor uterine contraction; monitor pushing efforts by client; monitor for increase in bloody show or shaking of extremities; monitor FHR every 5-15 min

b. third stage - blood pressure, pulse, and respiration rate every 15 min; clinical findings of placental separation from the uterus; apgar score assigned to neonate
c. fourth stage - maternal vital signs; fundus; lochia; urinary output; baby-friendly activities of the family

38. What are the signs of placental separation and how long can it take for the placenta to be expelled?
    a. Signs of placental separation indicated by: fundus firmly contracting, swift gush of dark blood from introitus, umbilical cord appears to lengthen as placenta descends, vaginal fullness on exam
    b. placenta is typically delivered within 5 minutes after delivery of the baby; if not delivered within 30-60 minutes medical interventions must be taken

39. What is the difference between a laceration and an episiotomy?
    a. episiotomy- incision made into the perineum to enlarge the vaginal opening to facilitate birth and minimize soft tissue damage
    b. laceration- often forms on its own during vaginal birth

40. What are the normal blood loss amounts for a vaginal and a cesarean delivery?
    a. vaginal ~ 500 ml (half quart)
    b. c section ~ 1000 ml (quart)

41. List “post procedures” done during the fourth stage of labor.
    a. maternal VS
        i. BP q15 mins for first 2 hours, temp q4 hrs for first 8 hrs
    b. fundus- q 15 mins for 1hr and then protocol; massage
    c. lochia- q 15 mins for 1hr and then protocol; massage
    d. perineum- assess and provide comfort measures
    e. urinary output- encourage voiding to prevent bladder distention
    f. maternal/newborn baby-friendly activities- bonding

42. What are important interventions for the newborn at birth? Why is skin to skin time with mom so important?
    a. facilitates the release of endogenous maternal oxytocin

43. What does Apgar stand for? What 5 parameters does it assess? How often is it assessed?
    a. Appearance, Pulse, Grimace, Activity, Respiration
    b. 1 and 5 mins after birth
        i. 1 minute tells how baby took the birthing process
        ii. 5 minutes tells how baby is adapting to outside world

44. What important assessments as the nurse are you continuing to make, in relation to mom, during the third stage of labor?
    a. placental expulsion
    b. VS q 15 mins

c. administer analgesics
d. cleanse perineal area
e. allow private time to bond and promote breastfeeding